FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING\_ IL6000103 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **550 SOUTH MULFORD AVENUE ALDEN DEBES REHAB & HCC** ROCKFORD, IL 61108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** S9999 Final Observations S9999 Statement Of Licensure Violation: 1 of 1 Violation: 300.1210b) 300.1210d)3)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary b) care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: Objective observations of changes in a resident's condition, including mental and Attachment A Statement of Licensure Violations emotional changes, as a means for analyzing and determining care required and the need for

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resident's medical record.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

further medical evaluation and treatment shall be made by nursing staff and recorded in the

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(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED C B. WING IL6000103 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE ALDEN DEBES REHAB & HCC ROCKFORD, IL 61108 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000103 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 SOUTH MULFORD AVENUE **ALDEN DEBES REHAB & HCC** ROCKFORD, IL 61108 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID !D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 3 S9999 R1's 8/8/2020 Emergency Department notes showed, "Patient has multiple linear abrasions and lacerations above (upper) extremities. About 12 on each upper extremity. She does have 2 lacerations (cuts) requiring suture repair on the left upper extremity of a 3 cm (centimeter) length each..." On 8/19/2020 at 1:52 PM, V2 Director of Nursing (DON), stated at approximately 3:30 PM on 8/8/2020 she responded to R1's call light. V2 said R1 wanted her to look at her arms at which time she noted the lacerations to bilateral upper arms. V2 said when she got R1 up to the bathroom she found 3 razors wrapped up in paper towels that was stuffed inside her pants. On 8/19/2020 at 8:45 AM. R1 was observed with multiple lacerations to both of her upper arms. The lacerations were red, scabbed, and some with bandages. R1 also had scars on bilateral arms that matched the appearance of previous self cutting attempt. On 8/19/2020 at 8:55 AM, R1 stated she had a history of cutting herself. R1 stated she was given a shaving razor by a hospitality aide and that was the razor she used to cut herself. R1 said, "I feel safer when they don't let me have those things."

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On 8/19/2020 at 11:47 AM, V4 Psychiatric Rehabilitation Services Coordinator (PRSC) stated, "In an ideal world, the counselors get the mail for the residents (on behavioral health units) and because of COVID the packages have to sit on a table for 24 hours. Then we (PRSC's) usually go and get the packages and bring it to the person. Packages are opened in front of us

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resident was done. V8 said, the facility has no

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE \$50 SOUTH MULFORD AVENUE ROCKFORD, IL 61108  (X4) D PREERY (EACH DEPRICENCY MUST BE PRECEDED BY PULL TAG  Separation of the period of the precipitation	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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